# Complete Summary

## GUIDELINE TITLE

Recommendations for the diagnosis and management of Alzheimer's disease and other disorders associated with dementia: EFNS guideline.

## BIBLIOGRAPHIC SOURCE(S)

Waldemar G, Dubois B, Emre M, Georges J, McKeith IG, Rossor M, Scheltens P, Tariska P, Winblad B, EFNS. Recommendations for the diagnosis and management of Alzheimer's disease and other disorders associated with dementia: EFNS guideline. Eur J Neurol 2007 Jan;14(1):e1-26. [253 references] PubMed

## GUIDELINE STATUS

This is the current release of the guideline.

## ** REGULATORY ALERT **

## FDA WARNING/REGULATORY ALERT

**Note from the National Guideline Clearinghouse (NGC)**: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- June 17, 2008 – Antipsychotics (conventional and atypical): The U.S. Food and Drug Administration (FDA) notified healthcare professionals that both conventional and atypical antipsychotics are associated with an increased risk of mortality in elderly patients treated for dementia-related psychosis. The prescribing information for all antipsychotic drugs will now include information about the increased risk of death in the BOXED WARNING and WARNING sections.

## COMPLETE SUMMARY CONTENT

IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

## SCOPE

### DISEASE/CONDITION(S)

- Alzheimer's disease (AD)
- Other disorders associated with dementia
    - Vascular dementia
    - Parkinson disease dementia
    - Dementia with Lewy bodies

**Note**: This guideline does not include treatment of mild cognitive impairment (MCI).

### GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Treatment

### CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Neurology
Psychiatry

### INTENDED USERS

Physicians

### GUIDELINE OBJECTIVE(S)

To present a peer-reviewed evidence-based statement for the guidance of practice for clinical neurologists, geriatricians, psychiatrists, and other specialist physicians responsible for the care of patients with dementia

### TARGET POPULATION

Patients with suspected or diagnosed Alzheimer's disease or other dementia disorders

### INTERVENTIONS AND PRACTICES CONSIDERED

#### Evaluation/Diagnosis

1. Medical history
2. Neurological and physical examination
3. Assessment of cognitive function
4. Assessment of behavioral and psychological symptoms
5. Assessment of activities of daily living
6. Assessment of co-morbidities
7. Blood tests
8. Neuroimaging (e.g., computed tomography, magnetic resonance imaging, single photon emission computed tomography, and positron emission tomography)
9. Electroencephalography, cerebrospinal fluid analysis, genetic testing, and tissue biopsy if indicated
10. Assessment of driving ability
11. Disclosure of diagnosis

### Management/Treatment

1. Cholinesterase inhibitors (ChEIs)
2. Memantine (alone or in combination with ChEIs)
3. Monitoring treatment with ChEIs and memantine
4. Conventional and atypical antipsychotics
5. Counseling and support for caregivers

**Note**: The following treatments were considered but not recommended due to insufficient evidence:

- Gingko biloba, anti-inflammatory drugs, nootropics, selegiline, estrogens, vitamin E or statins in the treatment or prevention of Alzheimer's disease
- Aspirin, gingko biloba, calcium antagonists, or pentoxifylline in the treatment of vascular dementia (VaD)
- Memantine in the treatment of VaD, Parkinson disease dementia and dementia with Lewy bodies

### MAJOR OUTCOMES CONSIDERED

- Reliability and accuracy of diagnostic tests
- Institutionalization or progression of disability over 3 years
- Cognitive function
- Behavioral symptoms
- Activities of daily living
- Global scales and global impression of change
- Caregiver time and total societal costs

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The evidence for this guideline was collected from Cochrane Library reviews, other published meta-analyses and systematic reviews, other evidence-based management guidelines in dementia, including the practice parameters from the American Academy of Neurology (AAN), and original scientific papers published in peer-reviewed journals before January 2006. For each topic, the evidence was sought in MEDLINE according to pre-defined search protocols.

## NUMBER OF SOURCE DOCUMENTS

Not stated

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

### Evidence Classification Scheme for a Diagnostic Measure

**Class I**: A prospective study in a broad spectrum of persons with the suspected condition, using a "gold standard" for case definition, where the test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy

**Class II**: A prospective study of a narrow spectrum of persons with the suspected condition, or a well-designed retrospective study of a broad spectrum of persons with an established condition (by "gold standard") compared to a broad spectrum of controls, where test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy

**Class III**: Evidence provided by a retrospective study where either persons with the established condition or controls are of a narrow spectrum, and where test is applied in a blinded evaluation

**Class IV**: Any design where test is not applied in blinded evaluation OR evidence provided by expert opinion alone or in descriptive case series (without controls)

### Evidence Classification Scheme for a Therapeutic Intervention

**Class I**: An adequately powered prospective, randomized, controlled clinical trial with masked outcome assessment in a representative population or an adequately powered systematic review of prospective randomized controlled clinical trials with masked outcome assessment in representative populations. The following are required:

a. Randomization concealment
b. Primary outcome(s) is/are clearly defined
c. Exclusion/inclusion criteria are clearly defined
d. Adequate accounting for dropouts and crossovers with numbers sufficiently low to have minimal potential for bias

e. Relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences

**Class II**: Prospective matched-group cohort study in a representative population with masked outcome assessment that meets a–e above or a randomized, controlled trial in a representative population that lacks one criteria a–e

**Class III**: All other controlled trials (including well-defined natural history controls or patients serving as own controls) in a representative population, where outcome assessment is independent of patient treatment

**Class IV**: Evidence from uncontrolled studies, case series, case reports, or expert opinion

## METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The scientific evidence for diagnostic investigations and treatments were evaluated according to pre-specified levels of certainty (class I, II, III, and IV), and the recommendations were graded according to the strength of evidence (grade A, B, or C, Good Practice Point) (See the "Rating Scheme for the Strength of the Evidence" and "Rating Scheme for the Strength of the Recommendations" fields). In addressing important clinical questions, for which no evidence was available, the task force group recommended 'good practice points' based on the experience and consensus of the task force group. Consensus was reached by circulating drafts of the manuscript to the task force members and by discussion of the classification of evidence and recommendations at four task force meetings during 2004 and 2005.

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In 2003, a task force was set up to develop a revision of the EFNS guideline on dementia published in 2000, with the aim to provide peer-reviewed evidence-based guidance for clinical neurologists, geriatricians, old age psychiatrists, and other specialist physicians responsible for the care of patients with dementia.

The task force panel appointed by the Scientific Committee of the European Federation of Neurological Societies (EFNS), included neurologists, and representatives from geriatrics and old age psychiatry, with clinical and research expertise in dementia, and a representative from the patient organization, Alzheimer Europe.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

### Rating of Recommendations for a Diagnostic Measure

**Level A rating** (established as useful/predictive or not useful/predictive) requires at least one convincing class I study or at least two consistent, convincing class II studies.

**Level B rating** (established as probably useful/predictive or not useful/predictive) requires at least one convincing class II study or overwhelming class III evidence.

**Level C rating** (established as possibly useful/predictive or not useful/predictive) requires at least two convincing class III studies.

### Rating of Recommendations for a Therapeutic Intervention

**Level A rating** (established as effective, ineffective, or harmful) requires at least one convincing class I study or at least two consistent, convincing class II studies.

**Level B rating** (probably effective, ineffective, or harmful) requires at least one convincing class II study or overwhelming class III evidence.

**Level C rating** (possibly effective, ineffective, or harmful) requires at least two convincing class III studies.

**Good Practice Points** Where there was a lack of evidence but consensus was clear, the Task Force has stated their opinion as good practice points.

## COST ANALYSIS

A systematic review on the use of computed tomography scanning in dementia concluded that scanning each patient under 65 years and treating only subdural haematomas would be the most cost-effective approach.

A meta-analysis on the cost-effectiveness of cholinesterase inhibitors concluded that on the basis of the current evidence the implications of the use of donepezil, rivastigmine or galantamine to treat patients with Alzheimer's disease are unclear.

## METHOD OF GUIDELINE VALIDATION

Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were validated according to the European Federation of Neurological Societies (EFNS) criteria (see the "Availability of Companion Documents" field in this summary).

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The levels of evidence (class I-IV) supporting the recommendations and ratings of recommendations (A-C, **Good Practice Points**) are defined at the end of the "Major Recommendations" field.

**Diagnostic Evaluation**

**Medical History**

The clinical history should be supplemented by an independent informant where available (**Level A**).

**Neurological and Physical Examination**

A general neurological and physical examination should be performed on all patients presenting with dementia (**Good Practice Point**).

**Assessment of Cognitive Functions**

Cognitive assessment is central to diagnosis and management of dementias and should be performed in all patients (**Level A**). Quantitative neuropsychological testing, ideally performed by someone trained in neuropsychology, should be considered in patients with questionable, prodromal, mild, or moderate dementia (**Level C**). The specialist physician should include a global cognitive measure and in addition more detailed testing of the main cognitive domains including memory, executive functions and instrumental functions (**Level C**).

**Assessment of Behavioural and Psychological Symptoms**

Assessment of behavioural and psychological symptoms of dementia is essential for both diagnosis and management, and should be performed in all patients (**Level A**). Symptoms should be actively enquired about from the patient and a closely involved carer using appropriate rating scales (**Good Practice Point**). Co-morbidity should always be considered as a possible cause (**Level C**).

**Assessment of Activities of Daily Living**

Impairment of activities of daily living due to cognitive impairment is an essential part of the criteria for dementia and should be assessed in the diagnostic evaluation (**Level A**). A semi-structured interview from the caregiver is the most practical way to obtain relevant information, and a panel of validated scales is available (**Good Practice Point**).

**Assessment of Co-Morbidity**

Assessment of co-morbidity is important in the evaluation of the patient with dementia, and should be performed not only at the time of diagnosis, but

throughout the course of the disease, with particular attention to episodes of sudden worsening of cognitive or behavioural symptoms (**Good Practice Point**).

### Blood Tests

The following blood tests are generally proposed as mandatory tests for all patients at first evaluation, both as a potential cause of cognitive impairment or as co-morbidity: blood sedimentation rate, complete blood cell count, electrolytes, calcium, glucose, renal and liver function tests, and thyroid stimulating hormone. More extensive tests will often be required, (e.g., vitamin B12 and serological tests for syphilis, human immunodeficiency virus [HIV], and Borrelia, in individual cases) (**Good Practice Point**).

### Neuroimaging

Structural imaging should be used in the evaluation of every patient suspected of dementia: Non-contrast computed tomography (CT) can be used to identify surgically treatable lesions and vascular disease (**Level A**). To increase specificity, magnetic resonance imaging (MRI) (with a protocol including T1, T2 and FLAIR sequences) should be used (**Level A**). Single photon emission computed tomography (SPECT) and positron emission tomography (PET) may be useful in those cases where diagnostic uncertainty remains after clinical and structural imaging work up, and should not be used as the only imaging measure (**Level B**).

### Electroencephalography (EEG)

The EEG may be a useful adjunct, and should be included in the diagnostic work up of patients suspected of having Creutzfeldt-Jakob disease or transient epileptic amnesia (**Level B**).

### Cerebrospinal Fluid (CSF)

CSF analysis with routine cell count, protein, glucose, and protein electrophoresis is recommended in patients with a clinical suspicion of certain diseases and in patients with atypical clinical presentations (**Good Practice Point**). CSF total tau, phospho-tau, and Ab42 can be used as an adjunct in cases of diagnostic doubt (**Level B**). For the identification of Creutzfeldt-Jakob disease (CJD) in cases with rapidly progressive dementia, assessment of the 14-3-3 protein is recommended (**Level B**).

### Genetic Testing

Screening for known pathogenic mutations can be undertaken in patients with appropriate phenotype or a family history of an autosomal dominant dementia. This should only be undertaken in specialist centres with appropriate counselling of the patient and family caregivers, and with consent (**Good Practice Point**).

Pre-symptomatic testing may be performed in adults where there is a clear family history, and when there is a known mutation in an affected individual to ensure that a negative result is clinically significant. It is recommended that the Huntington's disease protocol is followed (**Good Practice Point**).

Routine Apo E genotyping is not recommended (**Level B**).

### Tissue Biopsy

Tissue biopsy can provide a specific diagnosis of some rare dementias. This should only be undertaken in specialist centres in carefully selected cases (**Good Practice Point**).

### Disclosure of Diagnosis

Disclosure of diagnosis should be done tactfully and should be accompanied by information about the consequences and the progression of the disease, as well as useful contacts such as the local or national Alzheimer's association. In countries where this is possible physicians may also wish to encourage patients to draw up advance directives containing future treatment and care preferences (**Good Practice Point**).

## Management of Alzheimer's Disease (AD) and Other Disorders Associated with Dementia

### Treatment of Alzheimer's Disease

In patients with AD, treatment with cholinesterase inhibitors (ChEIs, donepezil, galantamine, or rivastigmine) should be considered at the time of diagnosis, taking into account expected therapeutic benefits and potential safety issues (**Level A**). Realistic expectations for treatment effects and potential side effects should be discussed with the patient and caregivers (**Good Practice Point**).

In patients with moderate to severe AD, treatment with memantine can be considered, alone or in combination with a ChEI, taking into account expected therapeutic benefits and potential safety issues (**Level A**). Realistic expectations for treatment effects and potential side effects should be discussed with the patient and caregivers (**Good Practice Point**).

Currently, there is insufficient evidence to consider the use of gingko biloba, anti-inflammatory drugs, nootropics, selegiline, oestrogens, vitamin E or statins in the treatment or prevention of AD (**Level A–C**).

### Treatment of Vascular Dementia (VaD)

ChEIs (currently evidence exists for donepezil) may be considered in patients fulfilling diagnostic criteria for VaD of mild to moderate severity (**Level B**). Realistic expectations for treatment effects and potential side effects should be discussed with the patient and caregivers (**Good Practice Point**). In the presence of severe focal neurological deficits, the accuracy of diagnosis and expected therapeutic benefits should be carefully considered based on the presumed contribution of sensory-motor impairment versus cognitive deficits to the overall disability of the patient (**Good Practice Point**).

There is insufficient evidence to consider the use of memantine in patients with vascular dementia (**Level B**).

There is insufficient evidence to support the use of aspirin, gingko biloba, calcium antagonists or pentoxifylline in the treatment of VaD (**Level A–C**).

Optimum management of vascular risk factors, including anti-platelet drugs, should be ensured, not only in vascular dementia, but also in patients with other dementias or co-morbid vascular disease (**Good Practice Point**).

### Treatment of Parkinson Disease Dementia (PD-D) and Dementia with Lewy Bodies (DLB)

Treatment with ChEIs (currently evidence exists for rivastigmine) can be considered in patients with PD-D or DLB (**Level A**), taking in account expected therapeutic benefits and potential safety issues. Realistic expectations for treatment effects and potential side effects should be discussed with the patient and caregivers (**Good Practice Point**).

There is insufficient evidence for the use of memantine in PD-D or DLB (**Level C**).

### Monitoring Treatment with ChEIs and Memantine

Efficacy and side effects should be regularly monitored during treatment (**Good Practice Point**). In case of rapid worsening or an apparent loss of efficacy discontinuation of treatment may be considered on a trial basis. Such patients should be closely monitored in order to assess withdrawal effects or worsening in which case the treatment should be re-started (**Level C**).

### Treatment of Other Dementia Disorders

There are no drugs available for the specific treatment of other degenerative dementias such as fronto-temporal dementia (FTD), progressive supranuclear palsy (PSP) and cortico-basal degeneration (CBD) (**Level C**). A number of pathological conditions and systemic or central nervous system disorders can be associated with dementia. Their specific treatment must be based on the underlying etiology (**Good Practice Point**).

### Treatment of Behavioural and Psychological Symptoms in Dementia

Clinicians treating patients with dementia should be aware of the importance of treating behavioural and psychiatric symptoms and the potential benefits for patient and carer (**Good Practice Point**). Somatic co-morbidity should be considered as the cause of the symptoms (**Level C**). Non-pharmacological and then pharmacological interventions for behavioural and psychological symptoms of dementia (BPSD) may both be effective and should be applied in a targeted symptom approach. The short, medium and long term benefits and adverse effects of such interventions should be regularly reviewed (**Level C**). Antipsychotics, conventional as well as atypical, may be associated with significant side effects and should be used with caution (**Level A**).

### Counselling and Support for Caregivers

A dementia diagnosis mandates an inquiry to the community for available public health care support programs (**Good Practice Point**). Specialist physicians should assess caregiver distress and needs at regular intervals throughout the course of the disease (**Level C**). Caregivers should be offered support and counselling (**Level B**). This includes information about patient organizations (**Good Practice Point**).

### Legal Issues

Specialist physicians responsible for the care of patients with dementia should be aware of national legislations relating to assessment of capacity, consent to treatment and research, disclosure of diagnosis, and advance directives (**Good Practice Point**).

A diagnosis of dementia is not synonymous with mental incapacity, as a determination of capacity should always involve a 'functional' analysis: does the person possess the skills and abilities to perform a specific act in its specific context? (**Good Practice Point**).

### Driving

Assessment of driving ability should be done after diagnosis and be guided by current cognitive function, and by a history of accidents or errors whilst driving. Particular attention should be paid to visuospatial, visuoperceptual, praxis and frontal lobe functions together with attention. Advice either to allow driving, but to review after an interval, to cease driving, or to refer for retesting should be given (**Level A**). This decision must accord with the national regulations of which the specialist physician must be aware (**Good Practice Point**).

## Conclusion

The assessment, interpretation, and treatment of symptoms, disability, needs, and caregiver stress during the course of AD and other dementia disorders require the contribution of many different professional skills. Ideally, the appropriate care and management of patients with dementia requires a multidisciplinary and multi-agency approach. Neurologists should be involved together with old age psychiatrists and geriatricians in the development and leadership of multidisciplinary teams responsible for clinical practice and research in dementia. This review contributes to the definition of standards of care in dementia by providing evidence for important aspects of the diagnosis and management of dementia.

## Definitions:

### Evidence Classification Scheme for a Diagnostic Measure

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**Evidence Classification Scheme for a Therapeutic Intervention**

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b. Primary outcome(s) is/are clearly defined
c. Exclusion/inclusion criteria are clearly defined
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e. Relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences

**Class II**: Prospective matched-group cohort study in a representative population with masked outcome assessment that meets a–e above or a randomized, controlled trial in a representative population that lacks one criteria a–e

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**Class IV**: Evidence from uncontrolled studies, case series, case reports, or expert opinion

**Rating of Recommendations for a Diagnostic Measure**

**Level A rating** (established as useful/predictive or not useful/predictive) requires at least one convincing class I study or at least two consistent, convincing class II studies.

**Level B rating** (established as probably useful/predictive or not useful/predictive) requires at least one convincing class II study or overwhelming class III evidence.

**Level C rating** (established as possibly useful/predictive or not useful/predictive) requires at least two convincing class III studies.

**Rating of Recommendations for a Therapeutic Intervention**

**Level A rating** (established as effective, ineffective, or harmful) requires at least one convincing class I study or at least two consistent, convincing class II studies.

**Level B rating** (probably effective, ineffective, or harmful) requires at least one convincing class II study or overwhelming class III evidence.

**Level C rating** (possibly effective, ineffective, or harmful) requires at least two convincing class III studies.

**Good Practice Points** Where there was a lack of evidence but consensus was clear, the Task Force has stated their opinion as good practice points.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations" field).

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Appropriate diagnosis and management of Alzheimer's disease and other disorders associated with dementia

### POTENTIAL HARMS

**Adverse Effects of Medications**

- *Cholinesterase inhibitors (ChEIs)* are generally well tolerated, although gastrointestinal adverse effects such as nausea, diarrhea, and vomiting are the most common adverse effects, and may lead to discontinuation of treatment in some patients.
- A significant minority of patients with dementia with Lewy bodies experience worsening of agitation, paranoid delusions, and visual hallucinations when exposed to *memantine*.
- There are recent reports that *atypical antipsychotic medication* may be associated with an increased risk of cerebrovascular events and mortality in elderly patients with dementia. However, a retrospective cohort study suggested that *conventional antipsychotic medications* are at least as likely as

atypical agents to increase the risk of death amongst elderly persons, and more information is required to help clinicians make judgements about risk-benefits in individual patients. In dementia with Lewy bodies severe neuroleptic sensitivity reactions are associated with a two- to three-fold increased mortality, and antipsychotics should be used with great caution and only after careful estimation of risk-benefits.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- The guideline represents the minimum desirable standards for the guidance of practice, but does not include an analysis of cost-effectiveness of the recommended diagnostic and treatment interventions.
- This guideline may not be appropriate in all circumstances, and decisions to apply the recommendations must be made in the light of the clinical presentation of the individual patient and of available resources.
- In this guideline, the main emphasis is on recommendations for pharmacological treatment, and many important aspects of the care for patients with dementia, e.g., living arrangements, cognitive rehabilitation, nursing care and end-of-life issues are not covered. For pharmacological treatment, this review is confined to dementia (not mild cognitive impairment [MCI]) and to drugs which have been clinically tested in dementia and which are available on the market, although they may not be registered for dementia worldwide. Negative results were also included, if published, whereas experimental substances were not covered. It must be emphasized that the class of evidence does not necessarily reflect the effect size and the potential clinical relevance thereof, which were taken in consideration in making recommendations.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Federation of Neurological Societies has a mailing list and all guideline papers go to national societies, national ministries of health, World Health Organisation, European Union, and a number of other destinations. Corporate support is recruited to buy large numbers of reprints of the guideline papers and permission is given to sponsoring companies to distribute the guideline papers from their commercial channels, provided there is no advertising attached.

### IMPLEMENTATION TOOLS

Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Living with Illness

### IOM DOMAIN

Effectiveness
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Waldemar G, Dubois B, Emre M, Georges J, McKeith IG, Rossor M, Scheltens P, Tariska P, Winblad B, EFNS. Recommendations for the diagnosis and management of Alzheimer's disease and other disorders associated with dementia: EFNS guideline. Eur J Neurol 2007 Jan;14(1):e1-26. [253 references] PubMed

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2007 Jan

### GUIDELINE DEVELOPER(S)

European Federation of Neurological Societies - Medical Specialty Society

### SOURCE(S) OF FUNDING

European Federation of Neurological Societies

### GUIDELINE COMMITTEE

European Federation of Neurological Societies Task Force on Alzheimer's Disease

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## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Potential conflicts of interest: Gunhild Waldemar, Bruno Dubois, Murat Emre, Ian McKeith, Philip Sheltens, Peter Tariska, and Bengt Winblad have received speaker's and/or consultancy honoraria from Janssen-Cilag, Lundbeck, Mertz, Novartis, and/or Pfizer. Jean Georges: none declared. For the conception and writing of this guideline no honoraria or any other compensations were received by any of the authors.

## GUIDELINE STATUS

This is the current release of the guideline.

## GUIDELINE AVAILABILITY

Electronic copies: Available to registered users of the European Federation of Neurological Societies Web site.

Print copies: Available from Gunhild Waldemar, Professor, MD, DMSc; Department of Neurology, Copenhagen University Hospital, Rigshospitalet, section 6702, 9 Blegdamsvej, DK-2100 Copenhagen, Denmark; Phone: +45 35452580; Fax: +45 35452446; E-mail: gunhild.waldemar@rh.hosp.dk.

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Brainin M, Barnes M, Baron JC, Gilhus NE, Hughes R, Selmaj K, Waldemar G; Guideline Standards Subcommittee of the EFNS Scientific Committee. Guidance for the preparation of neurological management guidelines by EFNS scientific task forces – revised recommendations 2004. Eur J Neurol. 2004 Sep;11(9):577-81. Electronic copies: Available in Portable Document Format (PDF) from the European Federation of Neurological Societies Web site.
- Guideline papers. European Federation of Neurological Societies. Electronic copies: Available from the European Federation of Neurological Societies Web site.
- Continuing Medical Education questions available from the European Journal of Neurology Web site.

## PATIENT RESOURCES

None available

## NGC STATUS

This NGC summary was completed by ECRI Institute on April 23, 2009. The information was verified by the guideline developer on June 12, 2009.

## COPYRIGHT STATEMENT



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## NGC DISCLAIMER

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